No. 86-1488

In the Supreme Court of the United States

OCTOBER TERM, 1986

GEOFFREY A. DI BELLA, PETITIONER

v.

UNITED STATES OF AMERICA

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF FOR THE UNITED STATES IN OPPOSITION

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QUESTIONS PRESENTED

1. Whether the district court properly instructed the jury with regard to the element of intent in a prosecution of a physician for unlawfully dispensing drugs.

2. Whether the indictment properly included a number of prescriptions for drugs in a single count.

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OPINION BELOW

The opinion of the court of appeals (Pet. App. A1-A4) is unreported.

JURISDICTION

The judgment of the court of appeals was entered on November 19, 1986. A petition for rehearing was denied on January 15, 1987 (Pet. App. A5). The petition for a writ of certiorari was filed on March 11, 1987. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

Following a jury trial in the United States District Court for the Southern District of New York, petitioner was convicted on two counts of distribution of methaqualone, in violation of 21 U.S.C. 841(a)(1).[1] He was sentenced to

[1] Petitioner was acquitted on the conspiracy count. He had been indicted along with seven co-defendants. All eight were charged with

concurrent terms of two years' imprisonment, to be followed by a two-year term of special parole, and he was fined $5,000.

The evidence at trial established that petitioner was involved in the operation of sham medical clinics that dispensed prescriptions for Quaalude under the guise of treating stress or sleep disorders.[2] The clinics were begun by a Dr. Martin Feit, who started a "stress clinic" in his Staten Island office in early 1981 (Tr. 1406, 1866-1869). He recruited another doctor, co-defendant Greenfarb, to join him in writing Quaalude prescriptions (Tr. 1411). The clinic was forced to close in the summer of 1981 because people in the neighborhood complained that the customers were selling drugs outside the clinic (Tr. 585, 1412, 1870). Feit and Greenfarb then moved the business to Manhattan, where it flourished and expanded to additional locations. More doctors were hired, including petitioner. Tr. 504, 1220, 1266-1267, 1413, 1417-1418.

The clinics functioned ostensibly as legitimate medical practices, but it was clear from the actual operation of the clinics that their sole purpose was to sell as many

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conspiracy as well as various counts of distribution of methaqualone. Petitioner was tried with co-defendants Irving Greenfarb, Manuel Sanchez-Acosta, and Ariz Gourgi. Greenfarb was convicted on the conspiracy count as well as on two separate counts of distribution of methaqualone. Sanchez-Acosta was convicted on one count of distribution and acquitted on the conspiracy count. Gourgi was convicted on two substantive counts and acquitted on the conspiracy count. Three other defendants pleaded guilty; one remains a fugitive.

[2] "Quaalude" is the trade name for methaqualone. It is a hypnotic drug, which during the period at issue in this case was classified as a Schedule II controlled substance; it could be prescribed as a sleeping pill. Because of the widespread abuse of the drug, methaqualone has since been reclassified as a Schedule I controlled substance. As such, it may not lawfully be prescribed for medical purposes. 21 U.S.C. 829.

Quaalude prescriptions each day as possible, to virtually anyone who could pay the high fees. For example, although physical examinations were conducted, they were done entirely by physician's assistants, not by any of the medical doctors (Tr. 391). Staff members testified that urine samples were sometimes discarded without being analyzed, and that doctors prescribed Quaalude without even looking at the patients' electrocardiograms (Tr. 399, 1407). Patient history forms were completed, but they often contained patently false or inconsistent information, and simply recited boilerplate responses to indicate that the "patient" had sleep problems (Tr. 389, 871, 2113; GXs 20077, 20078, 20406, 40417, 40570). A doctor would typically spend about five to ten minutes with each client, and almost invariably write him or her a prescription for Quaalude, for a fee of $150 to $200 in cash (Tr. 1132-1133, 1139, 1355, 1364).

Most clinic doctors, including petitioner, were paid a flat rate of $2,000 to $3,000 per day; co-defendants Greenfarb and Sanchez-Acosta were paid on a per patient basis of $20 or $40 for each prescription written. Records maintained by the clinics showed that all the doctors wrote Quaalude prescriptions for more than 90% of the patients they saw; petitioner wrote Quaalude prescriptions for 98.7% of the clients he saw (Tr. 166-170; GX 3). Over one 27-day period of seeing clients, petitioner wrote 771 Quaalude prescriptions, or an average of almost 30 per day. He failed to prescribe Quaalude for only eight customers he saw during that period (GX 3).

Two undercover agents from the Drug Enforcement Administration visited the clinics in 1981 and 1982. On December 3, 1981, one agent, using the name "Michael Bates," received a Quaalude prescription from petitioner after paying $200 in cash. Two weeks later the same agent, using an entirely different name, again saw petitioner and received another prescription. He was never questioned

about using different names. Tr. 1126, 1132-1133, 1135, 1139-1140. The other agent had a similar experience on two different visits, one week apart, with co-defendant Greenfarb (Tr. 1354-1359).

The government was also assisted in its investigation by a physician, Dr. Gregory Drezga, who agreed to accept a job at one of the clinics (Tr. 1645). On the first day of his employment, Dr. Drezga saw a patient who had previously received a Quaalude prescription from Dr. Greenfarb. Dr. Drezga, however, refused to give the patient a Quaalude prescription, but instead offered her a mild form of tranquilizer, Dalmane. The patient became extremely upset and refused to pay for her visit to the clinic. Tr. 1656, 1819-1825. When Dr. Drezga made it clear to the operators of the clinic that he would not prescribe Quaalude indiscriminately, he was asked to leave the clinic (Tr. 1658; GX 19). The same patient returned to the clinic on three subsequent occasions and was given Quaalude prescriptions, twice by petitioner and once by Greenfarb (Tr. 1826-1828; GXs 2397, 4134, 3001E, 3003N).

Three witnesses who were qualified as experts on sleep disorders and the use of sedatives testified that no good faith medical practice was being conducted at the clinics. They based their conclusions on several factors: the huge volume of prescriptions, the very short time spent with each patient, and the superficial nature of the notations on the patients' charts (Tr. 870, 2106); the fact that virtually none of the patients had been referred by other physicians, when just the opposite would be typical at a bona fide sleep clinic (Tr. 875, 2109-2110); the fact that the clinics' patients included very few older people, for whom sleep problems are quite common, and that the majority of the patients were in age groups in which Quaalude abuse is common (Tr. 893, 2125-2126); and the lack of any other treatment for sleep problems, when a variety of treatments are commonly recommended, such as psychotherapy or

behavior modification (Tr. 868, 2118). In fact, the experts testified that Quaalude is rarely prescribed as a treatment for sleep disorders, and that the defendants prescribed it indiscriminately and inappropriately in many cases (Tr. 862-863, 2077, 2108, 2131).

Each of the defendants testified. Each claimed that he had acted in good faith and had prescribed medication for what he believed were legitimate medical problems.

ARGUMENT

1. Petitioner contends (Pet. 11-20) that he was improperly convicted of illegally dispensing drugs because an erroneous standard of criminal intent was used to determine whether he had dispensed the drugs in the course of good faith medical treatment. He argues that the district court erred by giving an instruction under which the jury could have convicted him without regard to his subjective intent, based solely on an objective evaluation that petitioner's practice did not conform to accepted medical practices. He also claims that the use of an erroneous standard of intent caused the court of appeals to err in its evaluation of the sufficiency of the evidence. In fact, the instruction on intent correctly stated the law, and there is no doubt that the evidence in this case was sufficient to support the jury's verdict.

a. Petitioner takes issue with the following instruction (Pet. 7; Tr. 3528):

> "If a doctor dispenses a drug in good faith in medically treating a patient, [then the] doctor has dispensed the drug for a legitimate purpose in the usual course of medical practice; that is, he has dispensed a drug lawfully.
>
> Good faith in this context means good intentions and the honest exercise of the best professional judgment as to the patient's needs. It means the doctor

> acted in accordance with what he reasonably believed to be proper medical practice."

Petitioner argues that this instruction allowed the jury to ignore his subjective intent and to convict on the purely objective determination that his conduct in dispensing drugs was not in keeping with generally accepted medical practice.

Petitioner does not point to any instruction in which the jury was told that it could convict without regard to criminal intent. The instruction quoted above requires proof that the defendant was not acting with "good intentions" and in "the honest exercise of the best professional judgment." It therefore explicitly required proof of subjective intent.

Petitioner focuses on the words "reasonably believed" in the instruction and argues that those words convert the instruction from one requiring proof of subjective intent to one permitting conviction under an objective standard of liability. But the reference to "reasonable belief" in the quoted instruction did not have that effect at all. Rather, that term was used in conjunction with the reference to the standard of proper medical practice, in order to make clear to the jury that a physician is required to know of, and to conform to, accepted norms of medical practice when prescribing controlled substances. As the court of appeals made clear in its earlier decision in *United States* v. *Vamos,* 797 F.2d 1146, 1152 (1986), cert. denied, No. 86-936 (Jan. 12, 1987), the term "proper medical practice" refers to an objectively ascertainable standard of conduct deemed appropriate by the medical community, not to the idiosyncratic views of particular physicians. That standard of conduct is derived from the regulation governing the authority of physicians to prescribe controlled substances. The regulation, and the applicable statute, 21 U.S.C. 829, grant physicians a limited exemption from the general prohibition against distribution of controlled substances,

as long as the prescription is "issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice." 21 C.F.R. 1306.04(a). The regulation adds that an order "purporting to be a prescription issued not in the usual course of professional treatment" is not a "prescription" within the meaning of the stautory exemption for physicians. *Ibid.*

The court of appeals, both in this case and in *Vamos,* was referring only to what constitutes accepted medical practice when it stated that an objective standard is to be applied. There is no suggestion that the defendant physician's intent to commit a crime is irrelevant; the court's point was simply that the physician's own particular view of what is accepted medical practice does not control that aspect of the legal standard. If the rule were otherwise, a physician could too readily avoid the strict limitations that Congress sought to impose on the medical application of Schedule II substances, simply by asserting a belief—no matter how unreasonable—that the substance in question could properly be prescribed for a variety of medical conditions. See *United States* v. *Moore,* 423 U.S. 122, 138-145 (1975). The standard applied by the court of appeals is not one of strict liability: even if the physician's conduct is outside the scope of proper medical practice, the physician is protected from criminal liability if he believes he is acting according to proper medical standards, as long as that belief is reasonable. In light of the stringent restrictions imposed on the prescription of controlled substances, there is nothing improper about holding physicians to that modest standard. As the court of appeals noted in *Vamos,* "[t]o permit a practitioner to substitute his or her views of what is good medical practice for standards generally recognized and accepted in the United States would be to weaken the enforcement of our drug laws in a critical area" (797 F.2d at 1153).

The instructions given in this case do not conflict with any of the formulations approved by other courts of appeals. Petitioner alleges that there is a conflict between this case and decisions from several other circuits, claiming that those courts apply a subjective rather than an objective standard of liability for physicians charged with unlawfully prescribing controlled substances. This contention is incorrect for two reasons. First, as we have noted, the court in this case did not subscribe to an objective test for the element of intent. The defendant must be shown to have intended to distribute controlled substances and to have done so other than in a good faith effort to provide legitimate medical treatment. The court applied an objective standard only to the extent that it required that the physician's belief that he is engaged in proper medical practice be a reasonable one. Second, the other court of appeals decisions on which petitioner relies do not reject this approach. The Fifth Circuit, in *United States* v. *Greenfield,* 554 F.2d 179, 182 (1977), cert. denied, 439 U.S. 860 (1978), simply noted the general point that the inquiry into intent is a subjective one; the court did not suggest that the defendant's belief that he was engaged in proper medical practice could not be judged according to a test containing an objective as well as a subjective component. Indeed, a more recent Fifth Circuit case specifically approved a jury instruction on the issue of the defendant's belief regarding standard medical practices that contained both subjective and objective components. See *United States* v. *Norris,* 780 F.2d 1207, 1209 (5th Cir. 1986); accord *United States* v. *Voorhies,* 663 F.2d 30, 33-34 (6th Cir. 1981).[3]

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[3]Most of the other court of appeals cases cited by petitioner (Pet. 13 n.12, 15-16) as conflicting with the decision in this case do not even address the question of whether the test for determining the defendant's adherence to proper medical practice is in part an objective one. We are aware of no case in which a court of appeals has reversed a conviction because of a charge like the one given in this case, or even

b. Petitioner also claims that the court of appeals used a standard for assessing the sufficiency of the evidence that conflicts with decisions from other circuits. This claim is entirely without merit. The court below summarized the evidence briefly in finding that the evidence was quite clearly sufficient, and its review was very similar to that undertaken by other courts in like cases. Petitioner contends that the court of appeals failed to consider any of the "non-physician-like features" of petitioner's practice. In fact, the court of appeals considered the very type of factors urged by petitioner. The court observed that prescriptions for the same medication were written for more than 95% of petitioner's patients; the court referred to the very brief patient examinations and extremely high fees; and the court noted the expert testimony explaining that the medical operation was a sham (Pet. App. A 2). The court of appeals could have detailed the facts more elaborately, but it found that unnecessary in light of the abundant proof that petitioner was not engaged in a bona fide medical practice.

2. Petitioner also complains (Pet. 20-22) that he was charged in each count with the writing of numerous prescriptions, and that the evidence failed to prove that

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criticized such a charge. The Ninth Circuit has criticized a charge that could be read to suggest that a physician would be liable if he failed to act in accordance with recognized medical standards, but that charge did not contain the proviso that the physician would not be liable if he reasonably believed he was acting in accordance with such standards, as did the charge in this case. See *United States* v. *Boettjer*, 569 F.2d 1078, 1082 (9th Cir.), cert. denied, 435 U.S. 976 (1978). Subsequent to *Boettjer*, the Ninth Circuit approved and endorsed an essentially objective standard when it approved a jury instruction which said that prescribing a controlled substance to a narcotic addict who did not have a medical complaint other than addiction or withdrawal would not constitute the good faith practice of medicine. *United States* v. *Hayes*, 794 F.2d 1348, 1352 (9th Cir. 1986), cert. denied, No. 86-848 (Feb. 23, 1987).

each specific prescription was unlawfully written.[4] He claims a conflict in this respect with the Sixth Circuit's decision in *United States* v. *Kirk,* 584 F.2d 773, cert. denied, 439 U.S. 1048 (1978), in which the court stated that an "essential element in these counts is that a prescription was issued to a specific person in each count, unlawfully and knowingly for the purpose of distributing controlled substances" (*id.* at 786).

First, petitioner failed to raise this issue below and therefore may not raise it here. *Berkemer* v. *McCarty,* 468 U.S. 420, 443 (1984); *United States* v. *Lovasco,* 431 U.S. 783, 788-789 n.7 (1977). Moreover, to the extent his complaint is that the indictment was duplicitous, his failure to raise the claim before trial constitutes a waiver. Fed. R. Crim. P. 12(b)(2) and (f); *United States* v. *Lartey,* 716 F.2d 955, 968 (2d Cir. 1983).

In any event, it was not improper for the indictment to group large numbers of prescriptions together in each count. Petitoner's course of conduct at each clinic represented a single, continuing scheme. It therefore was not necessary to charge each act of writing a prescription in a separate count. None of the dangers commonly posed by duplicitous indictments was present here: inadequate notice of the charges, exposure to the risk of double jeopardy, prejudicial evidentiary rulings, and the risk of conviction by a non-unanimous verdict. *United States* v. *Robin,* 693 F.2d 376, 378-379 (5th Cir. 1982); *United States* v. *Berardi,* 675 F.2d 894, 897-899 (7th Cir. 1982).

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[4] Petitioner was charged in Count Eight with having unlawfully dispensed, between November 10, 1981, and February 18, 1982, at the 34th Street Clinic, "outside the scope of professional medical practice, approximately 33,240 dosage units of Quaalude." In Count Nine he was similarly charged with dispensing "approximately 5812 dosage units of Quaalude" at another clinic, between March 1, 1982, and June 30, 1982. Pet. App. A8.

The approach used in the indictment in this case, in which each count of the indictment alleged a pattern of prohibited conduct, did not create a conflict with the Sixth Circuit's decision in *United States* v. *Kirk, supra.* In that case, each of the counts to which the court of appeals was referring alleged a single illegal prescription. Obviously, the proof at trial in *Kirk* had to conform to those specific allegations. Because the Sixth Circuit was not addressing a case in which a pattern of unlawful conduct had been charged in each count, the passage from which petitioner quotes cannot be read to suggest that charging in that fashion would be improper.

In this case, in contrast with *Kirk,* it was alleged that all of the prescriptions for Quaalude issued by the defendants in the course of their operation of the named clinics were unlawful, because the clinics were not operated as genuine medical practices and were actually just outlets for illegal drug distribution. The proof at trial showed exactly that. The records maintained by the clinics and the testimony of staff and "patients," undercover agents, and several expert witnesses all established that none of the Quaalude prescriptions was issued for a bona fide medical purpose, because no true medical practice was being operated. In light of the allegations and corresponding proof in this case, there was no need for the jury to focus on each particular prescription and determine whether it was unlawfully written. The evidence was sufficient for the jury to find that petitioner unlawfully dispensed as many Quaalude prescriptions as the records showed he wrote at the "stress clinics."

CONCLUSION

The petition for a writ of certiorari should be denied.
Respectfully submitted.

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MAY 1987

U.S. GOVERNMENT PRINTING OFFICE: 1987—181-483/40346